Liver transplantation and severe acute alcoholic hepatitis: An ethical consideration

To the Editor:
We have read the excellent paper by Donckier et al. [1]. The authors conclude that there are no major ethical barriers in transplanting patients affected by severe alcoholic hepatitis (SAH), non-responder to medical therapy. We totally agree with this statement [2].

Some recent clinical experiences have shown how to achieve favourable outcomes post transplantation in patients affected by acute alcoholic hepatitis (AAH), non-responder to medical therapies [3].

Most Western societies proudly promote alcohol consumption through increasingly sophisticated advertising campaigns, but paradoxically patients with SAH are denied access to liver transplantation (LT). Moreover, it is internationally well-known that so-called “moderate” amounts of alcohol, particularly if associated with other risk factors, may lead to cirrhosis, and to the need for a LT [4,5]. Social drinkers are usually considered as classy, cultured, and responsible people, whereas alcohol-addicted persons are commonly labelled as depraved and are marginalized by society. Liver transplant in patients with SAH is not accepted in the absence of a 6-month period of abstinence from alcohol.

An interesting question arises from this problem: is it acceptable to allocate scarce resources to patients who do not meet classical admissions criteria?

To date, nobody has been able to establish a certain period of abstinence, which ensures no future alcohol relapses; apart from this fact, in case of SAH, the 3-month mortality rate is about 70%.

Can we assume the right to refuse a treatment option for a patient? Is similar behaviour, in light of new clinical evidence, ethically correct? Our primary purpose should be the care of our patient’s life. We should, then, do our best to modify and adapt our attitude towards alcohol-addicted patients. Obviously, some patients’ features, such as the presence of severe psychiatric comorbidities, or the absence of an adequate social support, should be taken into account. Nevertheless, in our opinion, there are two main variables that may guarantee the maintenance of alcohol abstinence after a liver transplant. The first one is the attendance at self-help groups. The second variable is the close cooperation with an Alcohol Addiction Unit (AU), and with expert Hepatologists who are able to deal with both the hepatological disease and the alcohol addiction problem [6].

Recently Addolorato et al. [7] have demonstrated that the presence of an Alcohol Addiction Unit within a liver transplant centre may significantly reduce the risk of alcohol relapse and the recurrence of disease after LT, and may allow liver transplantations in some selected patients, even in case of less than 6 months of abstinence.

In our clinical experience (published data) [2,8] seven patients, non-responder to therapies, with clinical evidence of SAH (Maddrey Discriminant Function >32) and hepato-renal syndrome, were submitted to transjugular intrahepatic portosystemic stent shunt (TIPS), and then submitted to transplant. Steroid therapy was contraindicated because of the presence of renal failure. All patients were followed-up by the Alcoholology Unit, and attended self-help groups. None of them have relapsed over the next 5 years.

It is necessary to turn the ethical tide toward a self-inflicted injury such as alcoholic liver disease (ALD). What are we, professional physicians, able to offer our patients beyond a routine palliative care to minimize the risk of relapses, and, subsequently, of graft deterioration?

We believe that selected patients, affected with SAH, and non-responding to therapies, should have the opportunity to undergo a liver transplant if supported by expert Hepato-alcoholologists, and self-help groups (Alcoholic Anonymous, Clubs of Alcoholics in Treatment) and other associations.

In the post-LT phase, the patient [9] should be surrounded by a protective network where medical social workers, and families cooperate closely with self-help associations; all of which significantly increases the chance of reducing relapses.

The relevant scientific community has the duty to promote scientific and cultural initiatives to inform the population, and to define guidelines that should be characterized by innovative healthcare activities in an area, such as those related to ethics, alcohol and transplantation, where too many uncertainties still do exist.

Conflict of interest

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References


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Reply to: “Liver transplantation and severe acute alcoholic hepatitis: An ethical consideration”

To the Editor:
We thank Gianni Testino and Paolo Borro for their comments on our paper [1].

As they first pointed, we agree that there are evident paradoxes in the attitude of our societies toward alcohol consumption. On the one hand, alcohol drinking is largely encouraged, namely by advertising campaigns, and moderate or “controlled” drinking remains a mark of social integration. On the other hand, addictive drinking still leads to global moral disapproval and social exclusion, alcoholic patients being considered as responsible for their disease. Testino and Borro also underlined that global judgment of the alcoholism based on the severity of the liver disease could lead to unfair patient categorization as similar alcohol consumptions could lead to very different outcomes in different individuals, according to genetic backgrounds [2] and/or other risk factors.

As the authors stated, we also consider that moral and societal appreciations strongly influence the entire debate about liver transplantation (LT) in alcoholic liver diseases and particularly in patients with severe alcoholic hepatitis (SAH). Of course, the discussion about LT in these patients is dramatically exacerbated in the current context of organ shortage. On ethical grounds however, we would like to suggest that the transplant community has the duty to regularly evaluate and re-evaluate the rules for organ allocation, aiming at ensuring the optimal use of a scarce therapeutic resource. The definition of the optimal graft use in this context remains debatable but, based on fundamental ethical principles, we propose that the primary aim of organ transplantation should be a life-saving procedure, in the absence of any other therapeutic alternative, leading to satisfactory long-term results such as long-term graft and patient survivals. Optimally, decisional algorithms should be based on objective and transparent data, independently from any moral, societal or cultural influences. In parallel, the indications for LT should not be considered as definitively established, and, we could expect that in the next years, better disease understanding and therapeutic advances in alcohol liver diseases but also in other conditions, such as in hepatitis C or in hepatocellular carcinoma, will significantly modify the listing strategies, both to restrict or to enlarge the inclusion criteria.

At this stage, of course, early LT in patients with SAH remains a challenging procedure. A first step has been made with an initial report showing satisfactory results in highly selected patients [3]. Yet, these first results have now to be confirmed in strict investigational frameworks, with longer follow-up and in larger patient population. In this process, the definition of accurate selection criteria has a critical importance. In that sense, it should be mentioned that a multicentre prospective study has been initiated, to identify and to validate various selection criteria [4]. Among these factors, we fully agree with Testino and Borro that familial and socio-professional environments, attendance to self-help groups and cooperation with alcohol units play a pivotal role.

We are convinced that a door has now been opened to propose LT in selected patients with SAH. Careful evaluation of the selection criteria and analysis of the long-term results, including overall survivals, analysis of alcohol relapses, eventually leading to subsequent graft damages, will constitute the next steps to fully validate this procedure.

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References


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